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No. 86-1419

IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,
Petitioners,
v.
COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, U.S. CONFERENCE OF MAYORS, NATIONAL LEAGUE OF CITIES, COUNCIL OF STATE GOVERNMENTS, INTERNATIONAL CITY MANAGEMENT ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, AND NATIONAL CONFERENCE OF STATE LEGISLATURES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

Whether Oregon's Medicaid plan, defining a class of patients for whom supplemental reimbursement is available at a "heavy cost care" rate, confers on health care providers and recipients a federal right enforceable under 42 U.S.C. § 1983.

Whether 42 U.S.C. § 1983 provides a federal court remedy for additional reimbursement under Oregon's Medicaid plan to claimants who have bypassed the congressionally mandated administrative review procedures included in the plan.

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BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, U.S. CONFERENCE OF MAYORS, NATIONAL LEAGUE OF CITIES, COUNCIL OF STATE GOVERNMENTS, INTERNATIONAL CITY MANAGEMENT ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, AND NATIONAL CONFERENCE OF STATE LEGISLATURES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*

The *amici* are organizations whose members include state, county, and municipal governments and officials throughout the United States. *Amici* and their members have a compelling interest in legal issues that affect state and local governments.

This case is of importance to *amici* because it is another example of the proliferation of actions filed under 42 U.S.C. § 1983 against States and their political subdivisions to vindicate alleged federal rights arising from federal grant programs. Such litigation disrupts the federal-state relationship under these programs and undermines the States' functions and prerogatives.

This case arises out of the State's administration of its Medicaid program. Medicaid, a cooperative federal-state program that provides funds for medical services for the needy, leaves to each State the determination of eligibility requirements and reimbursement rates for patients and health care providers. The federal law and regulations evidence two concerns: to provide adequate health care to Medicaid recipients and to contain costs. Federal law requires each State to administer its plan through a special state agency and to establish administrative hearing processes to resolve disputes.

State plans are subject to review and approval by the United States Department of Health and Human Services. Oregon's plan, which has been approved, provides for reimbursement of long-term care facilities at a rate

of costs incurred by the lower 75% of all eligible facilities in Oregon. Oregon has also provided a special higher reimbursement rate for "heavy cost care" patients, defined as functional quadriplegics not requiring acute hospital care. Respondents' specific claim in this lawsuit is that Oregon incorrectly failed to classify certain patients as "heavy cost care" patients, and therefore failed to reimburse their health care providers at the higher "heavy cost care" rate. Respondents assert generally that the alleged misclassification of these patients violates their rights under constitutional, federal, and state law; but they can point to no specific violation of the detailed federal law and regulations.

The ruling below permits respondents to bypass state procedures established in accordance with federal law in order to assert in federal court rights that exist only by virtue of a state regulation. The decision turns every alleged misstep in the administration of a federal-state cooperative program into a federal case and exposes States and their political subdivisions to heavy potential financial liability. It also denigrates the state administrative procedures mandated by Congress by making the federal courts the initial claims agency for all dissatisfied Medicaid health care recipients and providers. Finally, it permits a federal court to define, in the first instance, a right that is a creature of state law. Thus, the decision below, in both its substantive and procedural aspects, poses a threat to the independence and integrity of the sovereign States in our federal system.

Amici submit that the decision below is wrong. Because this Court's decision will have a direct effect on matters of prime importance to *amici* and their members, *amici* submit this brief to assist the Court in its resolution of the case.[1]

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[1] Under Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. Their letters of consent have been filed with the Clerk of the Court.

STATEMENT OF THE CASE

Respondent Coos Bay Care Center, Inc. ("Coos Bay") is in the business of providing long-term health care services for profit to developmentally disabled and aged residents at its intermediate care facility located in Coos Bay, Oregon. A portion of Coos Bay's revenues are derived from its participation in the Medical Assistance Program, 42 U.S.C. § 1396a *et seq.* ("Medicaid program"), administered by petitioner State of Oregon, Division of Human Resources ("DHR").[2] Coos Bay believes that it is entitled to more money from DHR.

Oregon, like every State, has citizens who cannot afford adequate health care. In order to assist these needy persons, Oregon chooses to participate in the Medicaid program, a federal-state partnership designed to provide health care services to the poor. *See Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985). Under Medicaid, the federal government provides the bulk of the funding and general supervision of medical care of the needy, while the States actually develop, administer, and implement the program in accordance with their own state Medicaid plans, which must be approved by the Secretary of Health and Human Services ("HHS"). *Ibid.* If the terms or administration of the state plan do not conform to federal standards, the Secretary of HHS is authorized to withhold all or part of the federal funding. 42 U.S.C. § 1396c. The Medicaid statute requires participating States to "provide for procedures of prepayment and post-payment claims review." 42 U.S.C. § 1396a(a)(37)(B).

Oregon's Medicaid plan sets up a two-tier system for reimbursing health care facilities ("providers") such as

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[2] The other parties before the Court are Richard Ladd, Administrator of the DHR division directly administering Oregon's Medicaid program; Hannah Schwanke ("Schwanke"), guardian *ad litem* of David and Steven Schwanke; and Sandy Mauer ("Mauer"), guardian *ad litem* of Tami Mauer. David and Steven Schwanke and Tami Mauer are residents at Coos Bay.

Coos Bay. At level one, pursuant to Or. Admin. R. 411-70-085(1), providers that choose to participate in Oregon's Medicaid program are reimbursed for "all services, supplies, and facility equipment required for care," so long as the providers' claimed costs fall within "the [lower] 75th percentile ranking" of all eligible facilities in terms of costs ("the established rate"). Or. Admin. R. 411-70-440.[3] At level two, an additional "heavy cost" reimbursement rate is available for the care of a narrowly defined class of patients: functional quadriplegics "ready for discharge from an acute care hospital or whose care could be provided in a nursing facility in lieu of placement in an acute care hospital." Or. Admin. R. 411-70-030(1)(b).

The instant litigation arises out of a contract entered into by Coos Bay and DHR in the spring of 1982.[4] Under the agreement, Coos Bay was to provide health care services to persons qualifying for Medicaid assistance in return for reimbursement by DHR pursuant to Oregon's Medicaid plan. An addendum to the contract entitled Coos Bay to additional compensation for the care of persons certified by DHR as eligible for "heavy cost care." DHR concluded that the respondent residents of Coos Bay did not qualify as "heavy cost care" patients, that the addendum to the contract was therefore inapplicable, and that Coos Bay was entitled only to the established rate of reimbursement.

Respondents disagreed and brought suit *directly* in federal district court under, *inter alia*, 42 U.S.C. § 1983,

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[3] That is, if a facility's claimed costs fall within the lower 75% of those incurred by all facilities, Oregon reimburses the facility for all its costs. If the claimed costs are greater than those incurred by facilities within the lower 75th percentile, Oregon reimburses the facility at the 75th percentile rate and no more.

[4] Pursuant to federal requirements, 42 U.S.C. § 1396a(a)(27), health care facilities like Coos Bay agree to participate in the Oregon Medicaid program by entering into a "provider contract" with DHR. That contract binds the intermediate care facility to the applicable Oregon statutes and administrative rules.

seeking damages, injunctive and declaratory relief, and certification as a class action. In so doing, respondents bypassed the state rate reimbursement review procedures established by Oregon in accordance with Congress' command. 42 U.S.C. § 1396a(a)(37)(B). Specifically, rate reimbursement disputes are to be resolved by an impartial administrative decisionmaker after a hearing in which the provider may introduce all pertinent evidence. Or. Admin. R. 461-09-000. A provider dissatisfied with the administrative hearing officer's decision may appeal that determination to the Oregon Court of Appeals. Or. Rev. Stat. §§ 183.482, 183.484. Respondents failed to avail themselves of this review process.

Respondents do not complain that Oregon's Medicaid plan itself violates federal law. Rather, respondents' essential contention is that, under the provider contract and applicable state regulations, Coos Bay is entitled to more money for its care of certain Medicaid patients who ought to qualify for "heavy cost care." The individual respondents complain that the failure to reimburse Coos Bay at the "heavy cost care" level deprives them of the full range of appropriate care, but they allege no specific injury.

The case was assigned to a United States Magistrate for findings and recommendations. Ruling on petitioners' motion to dismiss for failure to state a claim on which relief could be granted, the magistrate concluded that, under the facts alleged, 42 U.S.C. § 1396a *et seq.* did not create enforceable rights or a private right of action and that respondents therefore could not sue under 42 U.S.C. § 1983. The United States District Court for the District of Oregon adopted these findings and dismissed respondents' complaint with prejudice and without leave to amend.

The United States Court of Appeals for the Ninth Circuit reversed, holding that respondents' complaint did

state a claim cognizable under Section 1983. The court of appeals reasoned that: (1) under *Maine v. Thiboutot*, 448 U.S. 1 (1980), all actions based on violations of the Social Security Act, of which Medicaid is a part, are cognizable through Section 1983 actions; and (2) even if analyzed under the test enunciated most recently in *Wright v. City of Roanoke Redevelopment & Housing Authority*, —— U.S. ——, 107 S.Ct. 766 (1987), (a) respondents had a right for purposes of Section 1983 because they were among the class especially intended to be benefitted by Medicaid, and (b) the state administrative remedy that Congress "permitted" the States to offer for violations of that right was not sufficiently comprehensive to indicate congressional intent to preclude resort to Section 1983 actions. *Coos Bay Care Center v. Oregon Dept. of Human Resources*, 803 F.2d 1060, 1062-63 (9th Cir. 1986) (*"Coos Bay"*).

SUMMARY OF ARGUMENT

I. Title 42 U.S.C. § 1983 provides a remedy only for the deprivation of a right, privilege, or immunity secured by the Constitution or by federal law, and only when Congress has not indicated an intent to foreclose such a remedy.

The complaint in this case alleges a violation only of state law. Respondents rely on a regulation of the Oregon Department of Human Resources, claiming that its inclusion in the State's Medicaid plan gives it the force and effect of a federal law for purposes of Section 1983. This novel theory finds no support in the language of the Medicaid statute, its legislative history, judicial precedent, or federal agency interpretations.

Medicaid is a federal-state cooperative endeavor to provide medical services for the needy. The federal law itself establishes no entitlement to any particular level of patient care reimbursement. It permits each participating State to develop its own plan and reimbursement rates; amendments to the original law have granted to the States progressively wider discretion in determin-

ing rate-setting methodology. To treat the elements of an individual State's plan as federal law would undermine the scheme of federal-state cooperation under Medicaid and under numerous other federal grant programs that establish a similar role for States. Section 1983 actions would become a commonplace to challenge alleged departures by the States from their own regulations.

Respondents' assertion of a federal right to "reasonable and adequate" reimbursement under the Medicaid statute finds no support in the language of the federal law. The statute requires only that a state plan provide for reasonable and adequate reimbursement. By not setting any particular reimbursement rate, the statute discloses a systemic focus rather than an intent to create individual rights. Moreover, extensive state liability should not be inferred from the requirement that participating States provide "assurances" satisfactory to the Secretary of HHS.

The court below erroneously concluded that respondents had a right under Section 1983 on the ground that they were among the intended beneficiaries of the Medicaid program. Decisions of this Court have made it clear that an intended benefit is not sufficient to create an enforceable right. Moreover, providers like Coos Bay are not among the intended beneficiaries of Medicaid. Respondents' argument that the "reasonable and adequate" reimbursement standard in the Medicaid statute, independent of Oregon's plan, requires that they receive payment for "heavy cost care" would nullify the carefully crafted scheme for state administration of the Medicaid system in accordance with state plans and would turn the federal courts into glorified Medicaid claims adjusters.

Even if respondents derived some right from the Medicaid law, the comprehensive remedies set forth in that statute indicate that Congress intended to foreclose its enforcement under Section 1983. These remedies include initial review of state plans by HHS before they

are approved; ongoing federal review and supervision of state plan administration; the authority given to HHS to cut off funding, either in whole or in part; and the statutory requirement that the States provide both prepayment and postpayment administrative review procedures. The expressed congressional preference for claims review at the state level precludes initial recourse to a Section 1983 remedy.

II. Assuming, *arguendo*, that the Medicaid statute could be read to confer on respondents an enforceable right to "heavy cost care" reimbursement, Section 1983 does not afford them a remedy at this stage. Until they have invoked the administrative remedy mandated by Congress, there has been no final denial of any such right. The State's action is neither final nor complete, because respondents have failed to invoke the administrative review which might have resulted in action favorable to them. The very statute on which respondents rely requires utilization of the state hearing mechanisms that respondents have bypassed. Respondent Coos Bay, moreover, in its contract with DHR, bound itself to the procedures provided by the State for protection of its rights.

Finally, even if respondents' failure to invoke the congressionally mandated administrative review procedure does not absolutely bar them from pursuing a remedy under Section 1983, the federal courts, out of deference to congressional intent and considerations of comity, should abstain from deciding whether the State's regulation applies to these respondents.

ARGUMENT

I. RESPONDENTS CANNOT STATE A CLAIM UNDER 42 U.S.C. § 1983 FOR PETITIONERS' FAILURE TO REIMBURSE THEM AT OREGON'S "HEAVY COST CARE" RATE.

A cognizable claim under 42 U.S.C. § 1983 has three distinct predicates. The claim must (1) arise out of the deprivation of an enforceable *right* (*see Pennhurst State*

School and Hospital v. Halderman, 451 U.S. 1, 22 (1981) (*"Pennhurst I"*)), (2) that is secured by *federal* law (*see Martinez v. California*, 444 U.S. 277, 285 (1980)), (3) for which Congress has not provided a comprehensive remedy (*see Middlesex County Sewerage Authority v. National Sea Clammers Ass'n*, 453 U.S. 1, 20-21 (1981) (*"Sea Clammers"*)). Because respondents have not satisfied even one of these requirements, their action is not cognizable under Section 1983.

A. The Right Asserted By Respondents Arises From State Law, Not Federal Law.

Violations of state law do not give rise to actions under 42 U.S.C. § 1983. *See Paul v. Davis*, 424 U.S. 693, 694, 699-702 (1976). Section 1983 affords relief only to a plaintiff deprived of a right, privilege, or immunity secured by the Constitution or *federal* law. *See Martinez v. California*, 444 U.S. at 285. That predicate is lacking in this case.

Respondents filed suit seeking "more money for services rendered to certain persons eligible for state and federal medical assistance." Magistrate's Findings and Recommendations, Pet. App. 10. Their complaint does not allege that Oregon's Medicaid program itself violates the requirement of federal law that plans provide reimbursement at levels "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). Instead, respondents ground their claim on alleged violations of Or. Admin. R. 411-70-030 and Coos Bay's contract with DHR.[5] Respondents' claim under Section 1983, therefore, depends on the proposition that state plans and regulations enacted pursuant to federal statutes are federal laws for purposes of Section 1983.

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[5] This fact, among others, serves to distinguish the case at hand from *Maine v. Thiboutot*, 448 U.S. 1 (1980), where the Section 1983 action was based directly on the state agency's failure to comply with *federal* requirements under 42 U.S.C. § 602(a)(7) and not, as here, a *state* regulation that, in turn, is allegedly required by federal law.

Amici respectfully submit that the law, as well as common sense, is to the contrary.[6] Respondents' position that Oregon's Medicaid regulations are federal law for purposes of Section 1983 is inconsistent with the language and framework of the Medicaid statute; its legislative history, particularly the trend toward greater state discretion; and the interpretation of the relevant federal agency.

Medicaid is a federal-state "cooperative endeavor." *Harris v. McRae*, 448 U.S. 297, 308 (1980). The federal government approves plans submitted by each State for funding medical services to the poor and subsidizes a significant portion of the costs incurred by the States, but each State administers the program in conformity with its own plan. *See Alexander v. Choate*, 469 U.S. at 289 n.1. Originally, the States had no choice but to reimburse facilities like Coos Bay according to the cost methodology used by the federal government in administering Medicare. But in 1972, concerned about escalating costs, Congress adopted the "reasonable cost related standard" for reimbursement, thereby allowing States to make their own reimbursement decisions and giving them flexibility in achieving satisfactory payment arrangements with health care facilities. H.R. Rep. No. 231, 92d Cong., 1st Sess. 101 (1971).[7]

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[6] Even if the Court should conclude that respondents' claim alleges a violation of federal law, respondents are foreclosed from bringing a Section 1983 suit because they lack a right and because comprehensive remedies exist. See Part I.B., *infra*.

[7] As the court discussed in *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980):

> Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 287 (1972) . . . . Additionally, Congress intended

In 1980, by the Boren Amendment, Congress instituted the current requirement that state plans provide reimbursement rates "(determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary [of HHS], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). The Boren Amendment establishes two crucial points. First, the Amendment expanded, yet again, the States' discretion in developing and implementing reimbursement methodologies.[8] The Health Care Financing Administration ("HCFA")[9] has acknowledged the "*legislatively mandated* flexibility" that the statute provides to the States in determining reimbursement rates. 48 Fed. Reg. 56049 (1983) (emphasis added).

Second, Congress clearly indicated its intent that reimbursement rates were to be determined in accordance with *state*, not federal, methods and standards. HCFA has specifically declined to issue more "explicit criteria for Federal review of States' methods and standards for establishing payment rates" lest "such a list of criteria

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that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items.

[8] The legislative history behind the 1981 amendment extending the Boren Amendment to hospitals as well as other long-term care facilities indicates that

> [i]n eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States *greater latitude* in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.

H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981) (emphasis added).

[9] HCFA, an agency of HHS, must approve reimbursement rates set by state Medicaid plans. Its opinion is entitled to a measure of deference. *See Schweiker v. Hogan*, 457 U.S. 569, 588 (1982) (quoting *Blum v. Bacon*, 457 U.S. 132, 141 (1982)).

. . . be viewed as imposing Federal standards for payment rates, an effect that would be contrary to the legislative intent." 48 Fed. Reg. 56050 (1983). Thus, even if providers have a right to "reasonable and adequate" reimbursement,[10] the contours of that "right" are plainly defined by state, not federal, law.

The United States Court of Appeals for the Second Circuit has recently rejected an argument, like respondents', that provisions of state Medicaid plans confer rights under federal law. In *Oberlander v. Perales*, 740 F.2d 116 (2d Cir. 1984), a health care facility participating in Medicaid brought a Section 1983 action alleging that the State of New York had violated its own regulation in reducing the rate of reimbursement for providers. The provider argued that, because the regulation was required to conform with 42 U.S.C. § 1396a *et seq.*, a violation of the regulation was, *ipso facto*, a violation of the federal statute. The court of appeals held (*id.* at 119) (citations omitted):

> We reject this tortuous argument, which, if valid, would provide a jurisdictional basis for federal judicial review of every disputed state administrative ruling relating to Medicaid. "[S]uits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States," *Maine v. Thiboutot*, 448 U.S. 1, 4 . . . (1980) (quoting *Edelman v. Jordan*, 415 U.S. 651, 675 . . . (1974)), but there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law.

Oberlander reached the only sensible conclusion. A holding by this Court that a state Medicaid regulation becomes a federal law simply by virtue of its inclusion

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[10] Part I.B.1., *infra*, addresses Coos Bay's claim that it has a right to reimbursement at the "heavy cost care" rate because of the requirement that States provide "reasonable and adequate" reimbursement. 42 U.S.C. § 1396a(a)(13)(A).

in a state plan contemplated by federal law would have drastic practical consequences. The structure of the Medicaid statute is very common. Numerous federal-state cooperative endeavors provide federal funds to the States for programs that are contained in state plans approved by a federal agency.[11] Federal courts would be inundated with Section 1983 claims brought by businesses and individuals participating in other federally funded programs with complaints about the States' implementation of their own regulations.

Liability under Section 1983 would be particularly inequitable in cases such as this where the state regulations at issue almost certainly are not required by the Medicaid statute.[12] Oregon's "heavy cost care" component is paid in addition to the established rate approved by the Secretary of HHS as the rate that will reimburse efficiently operated facilities for services provided to Medicaid patients. No other state Medicaid plan contains a "heavy cost care" provision; and only ten other States have provisions for any supplemental reimbursement.[13]

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[11] See, *e.g.*, 7 U.S.C. § 2020(d) (Food Stamp program); 16 U.S.C. § 460*l*-8(d) (Land and Water Conservation Fund program); 20 U.S.C. § 1205(b) (Adult Education program); 20 U.S.C. § 1413 (Education of the Handicapped program); 42 U.S.C. § 654 (Child Support Enforcement program); 42 U.S.C. § 1786(f) (Special Supplemental Food Program for Women, Infants and Children); 42 U.S.C. § 9904(d) (Community Services Block Grant program).

[12] An interpretation of Section 1983 that might force the States to limit their exposure to liability by providing low benefits and minimal protections for Medicaid recipients should obviously be avoided.

[13] California provides special rates for the mentally disordered and the developmentally disabled. In Florida, the class ceiling may be waived in "very unusual and costly circumstances." In Illinois, higher rates may be negotiated for recipients "requiring exceptional care." Kentucky and Maryland have special rates for hospital-based facilities. Michigan has a special rate for facilities serving ventilator-dependent patients, and permits an individually negotiated rate for patients transferred to an SNF (skilled nursing

The "heavy cost care" rate, like other innovative and diverse Medicaid programs, is purely a matter of state law.[14] Congress did not intend "cooperative federalism" [15] to become federal co-option.

B. Respondents' Allegations Concerning Federal Law Do Not Establish A Right Enforceable Under Section 1983.

The complaint summarizes various provisions of the Medicaid statute and regulations. These references apparently led the court of appeals to infer an allegation that the reimbursement afforded Coos Bay was inadequate and therefore in violation of federal law (and not merely state regulations). Such an allegation, even if properly discerned in respondents' complaint, would not support an action under Section 1983.

According to this Court's most recent pronouncement, there are "two exceptions to the application of § 1983 to

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facility) from acute care to receive specialized and concentrated nursing and support services. Rate reimbursement in Nebraska takes account of the additional cost of caring for ventilator-dependent recipients. New Jersey has a special provision for the mentally retarded. Utah provides "reimbursement incentives" to nursing homes admitting patients from hospitals with special care needs that cannot be provided under existing SNF rates, and permits negotiation of special rates for patients requiring more care than can be provided under basic SNF rates. Virginia provides retroactive reimbursement under Medicare principles to institutions for mental diseases that provide SNF and ICF (intermediate care facility) care to individuals 65 or older, and to ICFs for the mentally retarded. Thirty-eight States and the District of Columbia have no special provisions for nursing home reimbursement based on patient classification. Arizona's plan provides no reimbursement at all for nursing home services. See generally 3 Medicare and Medicaid Guide (CCH) ¶¶ 15,550-15,660.

[14] Thus, in addition to its deficiencies in stating a cause of action under Section 1983, respondents' complaint raises serious Eleventh Amendment questions. *See Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89 (1984) (*"Pennhurst II"*).

[15] *Harris v. McRae*, 448 U.S. 297, 308 (1980) (describing the Medicaid program).

remedy statutory violations: where Congress has foreclosed such enforcement of the statute in the enactment itself and where the statute did not create enforceable rights, privileges or immunities within the meaning of § 1983." *Wright v. City of Roanoke Redevelopment & Housing Authority*, 107 S.Ct. at 770-71 (discussing *Smith v. Robinson*, 468 U.S. 992 (1984); *Sea Clammers*, 453 U.S. 1 (1981); and *Pennhurst I*, 451 U.S. 1 (1981)).[16] We address these exceptions in reverse order.

1. *Respondents' interest in reimbursement at the "heavy cost care" rate does not rise to the level of an enforceable right.*

Respondents appear to argue that a right to "reasonable and adequate" reimbursement inheres in 42 U.S.C. § 1396a(a)(13)(A). This interpretation comports with neither the plain language nor the fair meaning of the statute.

In determining whether a statute creates enforceable rights, the "key to the inquiry is the intent of the Legislature." *See Sea Clammers*, 453 U.S. at 13; *Pennhurst I*, 451 U.S. at 15. The search for that intent begins with the language of the statute itself. *See Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 197 (1976) (quoting *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756 (1975) (Powell, J., concurring)). Here, the pertinent statutory language is that

> [a] *State plan* for medical assistance must . . . provide . . . for payment . . . for . . . services provided under the plan through the use of rates (deter-

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[16] The court of appeals' holding that this case is controlled by *Maine v. Thiboutot*, 448 U.S. 1 (1980), is, therefore, wrong because it ignores this Court's decisions subsequent to *Thiboutot*, none of which even suggests that the exceptions identified in those cases do not apply to alleged violations of the Social Security Act. Moreover, in *Thiboutot*, the Court was not called upon to decide *whether* a federal law (specifically, the Aid to Families with Dependent Children Act) had been violated, but only whether attorney's fees were available under 42 U.S.C. § 1988 to redress a conceded violation of a federal law other than federal civil rights legislation.

> mined in accordance with methods and standards developed by the State . . .) *which the State finds*, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

This language simply cannot be read, as respondents wish, to confer on providers a right to a particular level of reimbursement. First, the statute speaks only of a state Medicaid plan, and not of actual reimbursement for providers. In fact, federal law does not require any specific plan, but only that the State, if it wishes to participate in Medicaid, have a plan approved by the Secretary of HHS. The focus, therefore, is on the state system and not on individual recipients of benefits. *Cf. Pennhurst I*, 451 U.S. at 22 (rather than conferring individual rights, Developmentally Disabled Assistance and Bill of Rights Act has "systemic focus"). Thus, if respondents have a right under the Medicaid program, it is no more than the right to a state *plan* providing for reasonable and adequate reimbursement to health care providers generally, and not to any particular reimbursement *rate*.

Second, any alleged right accorded by § 1396a(a)(13)(A) arises from the "assurances" required to be given to the Secretary of HHS. This Court has expressed skepticism whether an individual's interest in having a State provide its "assurances" to a federal agency in order to receive government funding is a " 'right secured' by the laws of the United States within the meaning of § 1983." [17] *Pennhurst I*, 451 U.S. at 28. Far-reaching in-

[17] In fact, respondents do not claim infringement of their "right" to a state Medicaid plan providing for "reasonable and adequate" reimbursement. Their complaint does not allege that Oregon's Medicaid plan itself violates the federal statute. Rather, respondents allege that Oregon has violated Coos Bay's "right" under 42 U.S.C. § 1396a(a)(13)(A) to be reimbursed at the "heavy cost care" rate. This "right," as demonstrated above, is not provided by the statute.

dividual rights and extensive state liability should not rest on inferences drawn from such assurances. If Congress had wished to create rights on behalf of providers to a particular level of funding, it would surely have been more explicit. *See Rose v. Rose*, —— U.S. ——, 107 S. Ct. 2029, 2035 (1987); *Alexander v. Choate*, 469 U.S. at 307-08 n.32.[18]

Completely ignoring the statutory language, the court of appeals held that respondents had a right enforceable through a Section 1983 action on the ground that the statute "was enacted for the special benefit" of respondents or their class. *Coos Bay*, 803 F.2d at 1063. As the court itself recognized, its entire analytical framework consisted of but *one* of the four factors identified by this Court in *Cort v. Ash*, 422 U.S. 66 (1975), as appropriate for determining whether a federal statute creates an implied right of action. *Coos Bay*, 803 F.2d at 1063. Not only does this approach contravene the Court's directive in *Sea Clammers* and *Pennhurst I* to examine statutory intent, but it also erroneously equates rights with intended benefits. Simply because Congress intends to benefit a class of persons through a statute does not mean it intends to create for them a *right* to the benefit conferred. *See Bowen v. Gilliard*, Nos. 86-504 & 86-561 (U.S. June 25, 1987), slip op. 16-17; *Heckler v. Turner*, 470 U.S. 184, 189-90 & n.3 (1985); *Pennhurst I*, 451 U.S. at 22.

Indeed, as reflected in this Court's recent decisions, funding statutes such as Medicaid, although undoubtedly intended to benefit certain individuals, may not create rights. For example, *Pennhurst I* dealt with the Developmentally Disabled Assistance and Bill of Rights Act, 42

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[18] The absence of merit in respondents' claim that the Medicaid statute entitles Coos Bay to a particular level of reimbursement is clear from the voluntary nature of Oregon's decision to join the program. State participation in the Medicaid program is entirely optional (*see Harris v. McRae*, 448 U.S. at 301), and respondents could assert no rights under *federal* law had Oregon elected not to participate.

U.S.C. § 6000 *et seq.*, which the Court recognized was intended to benefit the developmentally disabled. *See Pennhurst I*, 451 U.S. at 11. Yet, the Court, with specific reference to Medicaid, the very statute involved in this case, stated:

> In sum, nothing suggests that Congress intended the Act to be something other than a typical funding statute. *Far from requiring the States to fund newly declared individual rights*, the Act has a systemic focus, seeking to improve care to individuals by encouraging better state planning, coordination, and demonstration projects. *Much like the Medicaid statute . . .*, the Act at issue here was "designed as a cooperative program of shared responsibilit[ies], not as a device for the Federal Government to compel a state to provide services that Congress itself is unwilling to fund."

Id. at 22 (emphasis added) (quoting *Harris v. McRae*, 448 U.S. at 309).

More recently, in *Alexander v. Choate*, the Court rejected the contention by a class of handicapped persons that they were discriminated against under § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, because Tennessee's Medicaid plan imposed a limit of fourteen days of inpatient hospital care per year. Writing for a unanimous Court, Justice Marshall explained (469 U.S. at 302-03) (emphasis added):

> To the extent respondents further suggest that their greater need for prolonged inpatient care means that, to provide meaningful access to Medicaid services, Tennessee must single out the handicapped for *more* than 14 days of coverage, the suggestion is simply unsound. At base, such a suggestion must rest on the notion that the benefit provided through state Medicaid programs is the amorphous objective of "adequate health care." *But Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs.* Instead, the

benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not "adequate health care."

The federal Medicaid Act makes this point clear. *The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage,* as long as care and services are provided in "the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

Furthermore, even if the one-factor test used by the court below were appropriate, it is apparent that health care providers like Coos Bay are not among the intended beneficiaries of Medicaid. *See Geriatrics, Inc. v. Harris,* 640 F.2d 262, 265 (10th Cir.), *cert. denied,* 454 U.S. 832 (1981); *Green v. Cashman,* 605 F.2d 945, 946 (6th Cir. 1979); *see also Silver v. Baggiano,* 804 F.2d 1211, 1216 n.3 (11th Cir. 1986). As the United States Court of Appeals for the Second Circuit observed:

> That a particular nursing facility cannot survive without Medicaid participation was certainly not Congress' foremost consideration in its creation of the Medicaid program. . . . The benefits to a nursing home from its participation in Medicaid reimbursement results from nothing more than a statutory business relationship.

Case v. Weinberger, 523 F.2d 602, 607 (2d Cir. 1975) (footnote omitted). Indeed, the statutory language expressing the purpose of Medicaid appropriations is conspicuous in its failure to mention the interests of providers at all. 42 U.S.C. § 1396a. Medicaid was created to aid participating States "in funding of medical services for the needy" (*Alexander v. Choate,* 469 U.S. at 289 n.1), not for providers.[19]

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[19] Coos Bay sought to bring itself within the statute's fold by having the facility's residents, the true intended beneficiaries of

Respondents appear to argue that the denial of "heavy cost care" reimbursement deprives them of rights under federal law because they assert that 42 U.S.C. § 1396a (a) (13) (A) requires a reimbursement level that is "reasonable and adequate" and that this level is not met without the "heavy cost care" rate for certain Coos Bay residents. Significantly, this claim does not depend on the existence in the Oregon Medicaid plan of the "heavy cost care" rate. Thus, the same claim could be raised against every State, whether or not it had a "heavy cost care" rate. Were respondents' argument sufficient under Section 1983, the state plans, so carefully conceived as the linchpin of the Medicaid system, would become irrelevant. The federal courts would become glorified Medicaid claims adjusters, reviewing countless highly technical, individual reimbursement decisions. Not only would the case load swamp the federal courts, but the sure guidance furnished to States, recipients, and providers by written state Medicaid plans would give way to the vagaries of case-by-case adjudication.[20] The right urged by respond-

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Medicaid, join its complaint. This procedural ploy is exposed by: (1) the relief sought in the complaint, which was an increase in reimbursement rates for Coos Bay, not respondents Mauer and Schwanke; and (2) the absence of allegations by the individual respondents that they have been denied any direct payment due them or that they have been specifically injured. *Cf. Maine v. Thiboutot*, 448 U.S. 1 (1980) (complaint that State's failure to make allowance for cost of supporting children by current marriage in calculating benefits violated Aid to Families with Dependent Children statute). Moreover, the court of appeals was incorrect in its assertion that the interests of the classes of respondents are parallel. The only concern of residents at Coos Bay is to maximize their own health care. Coos Bay, on the other hand, as a for-profit corporation, presumably aims to maximize its profits. In short, a provider is not an intended beneficiary of Medicaid and does not become one simply by joining recipients as co-plaintiffs.

[20] The central role intended for state Medicaid plans is evidenced by the statute's framework. The detailed requirements found throughout the statute are all phrased in terms of what a state plan must provide. See 42 U.S.C. § 1396a *et seq.*; *see also Alexander v. Choate*, 469 U.S. at 289 n.1.

ents and accepted by the court below must be seen for what it is: a license to contest in federal court under Section 1983 every reimbursement term in a provider contract and every reimbursement rate decision made by a state Medicaid agency.

2. *Congress provided comprehensive remedies under the Medicaid statute in order to foreclose direct action under Section 1983.*

This Court has held that "[w]hen the remedial devices provided in a particular Act are sufficiently comprehensive, they may suffice to demonstrate congressional intent to preclude the remedy of suits under § 1983." *Sea Clammers*, 453 U.S. at 20. The critical consideration, again, is what Congress intended. *See Smith v. Robinson*, 468 U.S. at 1012-13.

The analysis must begin by defining the "right" to be protected by the remedies under examination. As we demonstrate in Part I.B.1, *supra*, the only right that respondents arguably have under the Medicaid program is a right to a state Medicaid plan that provides for reasonable and adequate reimbursement to health care providers, if the State participates in Medicaid. Respondents do not allege, and they could not prove, a deprivation of that right; Oregon has a state plan, and it has been approved by the Secretary of HHS. Even if the Medicaid statute could be read to create a right to reasonable and adequate reimbursement for providers (and not simply a plan to that effect), the remedies afforded for violations of that right are sufficiently comprehensive to foreclose recourse to Section 1983.

At the primary level, a state plan not complying with the Medicaid statute will fail to win the approval of the Secretary of HHS. 45 C.F.R. § 201.3(d) (1986). The plan must be a "comprehensively" written document (42 C.F.R. § 447.252(b) (1986)) that, among other things, "allow[s] interested parties an understanding of the ratesetting process and the items and services that are paid for through those rates." Department of

Health and Human Services, Health Care Financing Administration, State Medicaid Manual, 6-4 (April 1984).

Once approved, the plan is subject to continued scrutiny by the Secretary of HHS to ensure that federal requirements are satisfied. *See Charleston Memorial Hospital v. Conrad*, 693 F.2d 324, 327 (4th Cir. 1982). The Department of HHS, through its Audit Agency, conducts audits, annually or as appropriate, of the state Medicaid agency's operations. 45 C.F.R. § 201.12 (1986). The Social and Rehabilitation Service of HHS is authorized to conduct a review to ensure that the State is complying with federal substantive requirements. 45 C.F.R. § 201.10 (1986). State Medicaid agencies must, under 42 C.F.R. §§ 431.17, 431.18(f) (1986), maintain records and make program policy materials available to providers who request them. 48 Fed. Reg. 56051 (1983). If the Secretary of HHS determines that the State is improperly implementing its plan or not following a new federal requirement, he may either completely cut off federal funding (42 U.S.C. § 1396c; 45 C.F.R. § 201.6 (1986)), or "in his discretion," limit payments to "categories under or parts of the state plan not affected by such failure." 42 U.S.C. § 1396c.[21] In the matter at hand, the Secretary would have the option of terminating federal funds for only the portion of Oregon's Medicaid plan relating to "heavy cost care" patients.

The Medicaid statute provides the additional remedy of prepayment and postpayment claims review procedures at the state level. The court of appeals denigrated this remedy, believing that the review procedures were an optional feature of a state Medicaid plan. *See Coos Bay*,

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[21] This cut-off threat alone may constitute a sufficiently comprehensive remedy to foreclose recourse to Section 1983. For legislation such as Medicaid, enacted pursuant to the spending power, "the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but an action by the Federal Government to terminate funds to the States." *Pennhurst I*, 451 U.S. at 28.

803 F.2d at 1062 ("Title XIX *permits* states to establish administrative review procedures for disputes over Medicaid reimbursements.") (emphasis added). The court was in error. States are *required* to provide for review of disputed reimbursement decisions (42 U.S.C. § 1396a(a)(37)(B)); and a State must provide written assurances that this "essential" element of its reimbursement plan is met. 48 Fed. Reg. 56056 (1983). The review must take the form of "an appeals or exception procedure that allows individual providers an opportunity to submit *additional* evidence and receive *prompt* administrative review." 42 C.F.R. § 447.253(c) (1986) (emphasis added). Thus state administrative review must be both comprehensive and quick.

HCFA has found the claims review procedures of the Oregon Medicaid plan fully satisfactory, and respondents do not even allege that these procedures are in any way deficient. By administrative rule, health care providers and facility patients may contest DHR reimbursement and benefit decisions, and receive administrative review where, with the assistance of counsel, they may present all pertinent facts and evidence. Or. Admin. R. 461-09-000(3). If dissatisfied with the decision of the impartial administrative hearings official, providers or patients may obtain judicial review in state court under the Oregon Administrative Procedures Act, Or. Rev. Stat. §§ 183.482, 183.484. Thus, administrative and judicial review of both state benefit and reimbursement decisions were available to respondents as a matter of right. HCFA has recognized that implicit in this and other state claims review procedures are "fair and reasonable rate adjustments." 48 Fed. Reg. 56052 (1983).

Permitting a Section 1983 action would disrupt this comprehensive remedial scheme by moving the forum for rate reimbursement challenges from the States, where they belong, to the federal courthouse, where they do not. *Amici* submit that Medicaid reimbursement decisions, based as they are on extensive technical data, simply are

not conducive to efficient review by federal courts.[22] By contrast, administrative appeals procedures tailored to local conditions are designed to make precisely the sort of prompt, highly factual determinations inherent in rate reimbursement review.

If the judgment below is affirmed, it is readily foreseeable that a large number of providers dissatisfied with reimbursement rates will follow the path of Coos Bay to the perceived haven of the federal district court—particularly with the vision of 42 U.S.C. § 1988 attorney's fees ahead. The resulting burden on limited state resources and crowded federal dockets would be further compounded by the fact that rate reimbursement decisions are not one-time events. This Court has refused to assume that Congress intended to condition federal funds upon the States' incurring the enormous obligation of defending Section 1983 suits. *See Pennhurst I*, 451 U.S. at 24-25. This principle has special applicability where, as here, Congress has specified the remedy that the States must provide for rate reimbursement challenges and States such as Oregon have expended funds to meet this requirement. *See Tennessee Valley Authority v. Hill*, 437 U.S. 153, 188 (1978) (applying maxim of *expressio unius est exclusio alterius*).

Obviously, respondents, like the plaintiffs in *Smith v. Robinson* and *Sea Clammers*, would prefer to bring a Section 1983 action to remedy alleged violations of a federal statute and regulations rather than to seek relief through the review procedures required by the federal

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[22] *Maine v. Thiboutot*, 448 U.S. 1 (1980), stands in sharp contrast. In that case, the issue was whether, in computing Aid to Families with Dependent Children benefits (to which a father was entitled for his three children by a previous marriage), allowance should be made for money spent to support his five children by a current marriage. The claim was based on specific provisions of the federal statute and was a purely legal dispute, not requiring the technical, factual expertise demanded by Medicaid rate reimbursement challenges. Moreover, the claimant had pursued the State's administrative remedies and judicial review procedures.

statute. The determinative inquiry, however, is not the wishes of the plaintiff but the intention of Congress. *See Smith v. Robinson*, 468 U.S. at 1012 ("The crucial consideration is what Congress intended."). And clearly, Congress intended to foreclose Section 1983 actions for disputed rate reimbursement decisions.

II. RESPONDENTS' CLAIM IS NOT RIPE FOR RESOLUTION BY A FEDERAL COURT UNDER SECTION 1983 BECAUSE THEY HAVE NOT AVAILED THEMSELVES OF THE PROCEDURAL REVIEW MECHANISM MANDATED BY FEDERAL AND STATE LAW.

Even if Section 1983 actions were not foreclosed for disputes over rate reimbursement under Medicaid, respondents' action would be premature in light of Congress' intent that claims review occur at the state level, as well as settled judicial doctrines, such as finality and abstention, that preclude federal review at this time.

This case involves a disagreement between a state Medicaid agency and a Medicaid provider over the appropriate level of reimbursement for certain Medicaid recipients. Foreseeing the inevitability of such disputes, Congress ordained a remedy: States are required to establish procedures affording dissatisfied providers a right to appeal reimbursement decisions, thus ensuring quick claims review at the state level. 42 U.S.C. § 1396a(a)(37)(B). Consistent with the congressional command, HCFA will approve state Medicaid plans only if they contain procedures that implement Congress' goal of prompt and meaningful review. 42 C.F.R. § 447.253(c) (1986). HFCA considers this review process one of "the essential elements of a State's reimbursement system" and a prerequisite for judicial review. 48 Fed. Reg. 56056, 56052 (1983). In fact, HFCA declined to issue more specific regulations regarding the criteria for appropriate "assurances" that reimbursement rates are reason-

able and adequate, in part because of the availability of provider appeals. 48 Fed. Reg. 56050 (1983).

As this case illustrates, state administrative procedures cannot compete with the lure of the federal courts. A decision of this Court authorizing dissatisfied providers to proceed directly into federal court would render the state administrative procedures superfluous and 42 U.S.C. § 1396a(a)(37)(B) meaningless. *See Smith v. Robinson*, 468 U.S. at 1012 (precluding Section 1983 action for violation of the Education of the Handicapped Act in part because such a result would render provisions in the statute superfluous). More important, such a result would frustrate Congress' objective of ensuring timely administrative review.

In the closely related context of Medicare reimbursement, this Court recently held that, in light of Congress' intent that administrative procedures be used, the dissatisfied program participants before the Court had to avail themselves of their administrative remedies before proceeding to federal court. *See Heckler v. Ringer*, 466 U.S. 602 (1984). In deferring to Congress, the Court explained, in words fully applicable to Medicaid reimbursement (*id.* at 627) (footnote omitted):

> Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be balanced against the potential for overly casual or premature judicial intervention in an administrative system that processes literally millions of claims every year. If the balance is to be struck anew, the decision must come from Congress and not from this Court.

The policy rationale for preventing respondents from bypassing state procedural structures flows from the system of "cooperative federalism" of which Medicaid is a part. *See Harris v. McRae*, 448 U.S. at 308 (1980) (quoting *King v. Smith*, 392 U.S. 309, 316 (1968)). Pursuant to 42 U.S.C. § 1396a(a)(37)(B), Congress placed the responsibility for reviewing reimbursement

decisions upon the States because they are best able to determine a scheme of rates. Through the technical expertise of administrative tribunals and their knowledge of local conditions and concerns, States are particularly suited to provide the type of fast, efficient review that serves the interests of providers as well as state Medicaid agencies. Rate reimbursement disagreements may be more cheaply resolved at the state level before they become expensive Section 1983 lawsuits. Moreover, because the State-provider relationship is ongoing, interests of long-term stability require a less contentious forum than the adversarial arena of a federal district court. Finally, federal court litigation would compound the States' costs, for the States would remain obligated to fund the administrative review process. In short, authorization of Section 1983 actions would produce a costly, duplicative system of disputes resolution.

Reinforcing these policy considerations, as well as Congress' intent that rate reimbursement challenges be reviewed initially in the state forum, are several doctrines developed by this Court to avoid premature resolution of issues like those presented in this action.

One such doctrine is finality, both procedural and substantive. In the recent case of *Williamson County Regional Planning Comm'n v. Hamilton Bank*, 473 U.S. 172 (1985), the Court declined to review an action brought under 42 U.S.C. § 1983 alleging that a zoning Commission had taken the property of a developer without just compensation. The Commission had refused to approve a plat that conflicted with a zoning ordinance and subdivision regulations. Noting that the developer had not applied for any variances, the Court held that "the Commission's denial of approval does not conclusively determine whether [the developer] will be denied all reasonable beneficial use of its property, and therefore is not a final, reviewable decision." *Id.* at 194. *Williamson County* also held that the challenged state action was not "complete," with respect to the developer's

claim for taking without just compensation, until it had utilized the inverse condemnation remedies available under state law. *Id.* at 194-97.

Procedural finality and completeness are similarly lacking in this case because the reimbursement rate set by DHR does not conclusively determine the amount that Oregon will pay to Coos Bay for the care of the individual respondents. Like the developers in *Williamson County*, respondents abandoned the rate review process in midstream. The administrative decisionmaker may have determined that DHR was wrong, and Coos Bay right, in its interpretations of Oregon's Medicaid plan and regulations. Indeed, had Coos Bay utilized the review procedures as intended by Congress, petitioners, respondents, and three federal courts may have been spared the toll of lengthy litigation.[23] Whether defined as the entitlement to "reasonable and adequate" reimbursement under 42 U.S.C. § 1396a(a)(13)(A) or the right to "heavy cost care" under Oregon's own Medicaid regulations, respondents' right presupposes a reimbursement review process. Until that review occurs, Oregon cannot be said to have violated respondents' rights.[24]

The doctrine of abstention provides another basis for declining to review this action in its present procedural

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[23] *See FTC v. Standard Oil Co. of California*, 449 U.S. 232, 244 n.11 (1980) ("one of the principal reasons to await the termination of agency proceedings is 'to obviate all occasion for judicial review'") (quoting *McGee v. United States*, 402 U.S. 479, 484 (1971)).

[24] Respondents' reliance on *Patsy v. Florida Board of Regents*, 457 U.S. 496 (1982), is mistaken. *Patsy* addressed the issue whether 42 U.S.C. § 1983 itself required exhaustion of administrative remedies available under Florida law for claims alleging discrimination based on race and sex. The Court held that Section 1983 did not. The Court did not concern itself with whether an underlying federal statute required the use of state procedures, as is the situation here. Nor, as subsequent cases have revealed, does *Patsy* affect the applicability of doctrines other than exhaustion, *e.g.*, finality. *See Williamson County*, 473 U.S. at 194-97.

posture. Relying on *Younger v. Harris*, 401 U.S. 37 (1971), and its progeny, this Court has recently held that federal courts should abstain from adjudicating a Section 1983 action where: (1) the dispute concerns an important state interest; and (2) the state administrative proceedings are judicial in nature and provide the plaintiff a full and fair opportunity to air its federal claims. *See Ohio Civil Rights Comm'n v. Dayton Christian Schools*, —— U.S. ——, 106 S. Ct. 2718, 2723-24 (1986). The abstention doctrine applies to this case as well. Oregon clearly has a large stake in ensuring the adequate and efficient health care of its needy citizens; it participates in the Medicaid program to that precise end. Moreover, the Oregon plan's provision for a hearing before an impartial hearings official (Or. Admin. R. 461-09-000(3)), who is required to take prompt action (Or. Admin. R. 461-09-010(6)), and whose decision is subject to judicial review (Or. Rev. Stat. § 183.482), permits providers a full opportunity to present any "rights" that they might have under federal law.[25]

Bypass of the state administrative procedures is especially unfair given the factual and legal background of respondents' complaint. Coos Bay elected to do business with Oregon pursuant to its Medicaid program; indeed, it signed a contract agreeing to abide by the terms of

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[25] The procedures *mandated* by Congress for determining rate reimbursement constitute a *process* extending from the initial determination by the state Medicaid agency through review by a state administrative or judicial decisionmaker. 42 U.S.C. § 1396a(a)(37)(B) (prepayment *and* postpayment review required). Consequently, the Oregon Medicaid program, in which Coos Bay chose to participate, sets forth a two-step process for reimbursement decisions: preliminary determinations by DHR *and* review by an administrative hearings official. Or. Admin. R. 411-70-030, 411-70-440, 461-09-000 (3). Coos Bay may not escape the effect of *Younger* simply by choosing to abandon this scheme after DHR issued its decision denying Coos Bay "heavy cost care" reimbursement and before the process was complete. *Cf. Huffman v. Pursue, Ltd.*, 420 U.S. 592 (1975) (applying *Younger* where state trial court had issued injunction, but no appeal was taken, and no action was "pending").

the plan. Yet, as soon as DHR rejected its claim for "heavy cost care" reimbursement, Coos Bay chose to sever its participation with respect to state administrative procedures—the very mechanism for redressing Coos Bay's alleged injuries.

In any event, respondents' legal theory is selectively crafted simply for litigation purposes. To support their cause of action under Section 1983, respondents were required to establish a deprivation of a judicially enforceable federal right. They attempted to deduce such a right from the requirement in 42 U.S.C. § 1396a(a)(13)(A) that a state Medicaid plan provide for "reasonable and adequate" reimbursement. They chose, however, to ignore the procedure mandated in the same statute for state administrative review of provider appeals. 42 U.S.C. § 1396a(a)(37)(B). Clearly, if there is any "right" under the federal law to funding for medical costs, it is a right enforceable through the state forum provided by the same law. Thus, respondents are not properly before this Court because they have not availed themselves of the procedural review mechanisms required by federal and state law.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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